HOME VISIT REQUEST FORM

Apex Laboratory, Inc.

30 Undercliff Ave.
Elmsoford, NY 10523 - 3003
Tel: 914-963-3279 Fax:914-963-4709
Toll Free Fax:1-877-521-8482

Nassau, Suffolk, Queens, Brooklyn
FAX: 631-753-3910
Manhattan, S.I., Bronx, Westchester
FAX: 914-963-4709
Order ONLINE via our web based Scheduling system, www.apexlabinc.com (registration required)

THIS ORDER IS FOR A MEDICALLY NECESSARY HOME DRAW (See 1 Below)

☐ Check(✓) this box to indicate that the patient should be billed for the house call (See 2 below)

*PHYSICIAN / AGENCY

Agency (If Applicable)

Physicians Last Name | Physicians First Name

Address

City | State | Zip

Physicians/Agency Telephone ( ) | Physicians/Agency Fax ( )

NPI #

PATIENT INFORMATION

*Patient SS# or other unique identifier

*Patient Last Name | *Patient First Name

*Sex ☐ Male ☐ Female | *DOB / /

Address

City | State | Zip

Patient Home Telephone ( ) | Patient Cell Phone ( )

Alternate Contact

Alternate Contact Number ( )

TEST(S) REQUESTED

FASTING: ☐ YES ☐ NO

*TEST(S) NAME	*DIAGNOSIS (see 3 below)

BILLING INFORMATION

PLEASE CHECK (✓) ONLY ONE – Your Primary Insurance Company

☐ MEDICARE # _____

☐ RAILROAD MEDICARE #_____

☐ GHI MEDICARE #_____

☐ BILL PATIENT

☐ BILL AGENCY

☐ OTHER INSURANCE NAME_____

OTHER INSURANCE #_____

POLICY HOLDERS NAME: (If not patient)

_____

Patients Relationship to Policy Holder

☐ SELF ☐ SPOUSE ☐ DEPENDENT

IMPORTANT: To find out all insurances accepted please visit www.apexlabinc.com

WE WILL NOT PROCESS THIS ORDER WITHOUT AN APPROPRIATE DIAGNOSIS.

IF THIS SECTION IS NOT COMPLETED, ONLY ONE VISIT WILL BE SCHEDULED

Select Schedule :

☐ One Time Only

☐ Weekly - please circle - 1X 2X 3X (indicate day(s) below)

☐ Bi-Weekly (every other week) (Indicate day below)

☐ Monthly- every ___ month(s)

*Start Date _____ *End Date_____ **or**

Circle the number of months to continue **1 2 3 4 5 6**

Additional information_____

Day(s) of Week: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

STANDING ORDERS CAN NOT EXCEED SIX (6) MONTHS

1) **Medically Necessary Home Visits** – By sending this request, the ordering physician is certifying that the patient is homebound and that both the home visit and the lab test(s) that are being ordered are medically necessary.
2) **Patient Billable Home Visit** – For the patients that are not categorized as homebound, but request a phlebotomist come to their home, Apex Laboratory, Inc. will bill them $20.00 (subject to change) for the home visit and charge their insurance carrier for the draw and the test(s).
3) **ICD-9 Diagnosis Codes** – Medicare requires a diagnosis for every test ordered and a specific diagnosis for certain tests categorized as "Medicare Limited Coverage Tests". Without an appropriate diagnosis code (a narrative is acceptable), Medicare will not pay for the test(s), and we will not schedule these test(s).

***ARE REQUIRED WITH EVERY ORDER**

Revised 11/2011